FEMALE FAMILY PLANNING HEALTH HISTORY FORM

Please answer the questions below:

Last Name First	Date of birth	Age	Date today

Home phone number ( )	Message/pager number ( )	Best time to call

Are you allergic to any medicines, shellfish, or copper? **NO** ❒ **YES** ❒
Which ones and describe what happened:

Do you take (or are you supposed to take) medicines, natural remedies, aspirin, or other drugs every day? **NO** ❒ **YES** ❒
List them:

NO	YES	*Have you ever had or do you have:*	NO	YES	
❒	❒	Diabetes	❒	❒	Problems with your kidneys or bladder
❒	❒	Seizures	❒	❒	Bone disease or weak bones
❒	❒	Heart attacks or strokes	❒	❒	Cancer
❒	❒	High blood pressure	❒	❒	Breast surgery or problems
❒	❒	Depression	❒	❒	Pelvic infection treated in the hospital
❒	❒	Migraines	❒	❒	Uterine fibroids or Ovarian cysts
❒	❒	Blood clot in your blood vessels like the leg or lung	❒	❒	Eczema or bad skin rashes
❒	❒	Hepatitis (turned yellow)	❒	❒	Ectopic or tubal pregnancy
❒	❒	Any other serious medical condition, surgery, or hospitalization	❒	❒	Blood transfusions or IV Drug use

Has anyone in your **IMMEDIATE** family *(mother, father, sister, brother, daughter, son, or if your parents are less than 50 give information about other relatives)* had any of the following:

		NO	YES	DO NOT WRITE HERE
Cancer:	Who, what type and at what age found?	❒	❒	_____
Diabetes:	Who and at what age?	❒	❒	_____
Heart Attack:	Who and at what age?	❒	❒	_____
Stroke:	Who and at what age?	❒	❒	_____
Blood clots in blood vessels like the leg or lung?	Who and at what age?	❒	❒	_____

Our services are confidential, however, if you are under the age of 18 and share with us a history of sexual abuse *or rape we are required by law to report this to Child Protective Services. If you have questions about these laws, please ask.*

Do you use tobacco? **NO** ❒ **YES** ❒ How much do you use? _____ How many years? _____

Do you drink alcohol? **NO** ❒ **YES** ❒ How often? ❒ daily ❒ weekly ❒ monthly

How many alcoholic drinks do you have at one time? ❒ 1-2 drinks ❒ 3-4 drinks ❒ 5+ drinks

Do you use other drugs (examples: marijuana, cocaine, or IV drugs)? **NO** ❒ **YES** ❒

What do you use? _____ How often? ❒ daily ❒ weekly ❒ monthly

Do you feel safe from violence in your personal relationships? **YES** ❒ **NO** ❒

Have you ever had a sexually transmitted disease or genital infection? **NO** ❒ **YES** ❒

Circle the ones you might have had:

Chlamydia	Gonorrhea	Herpes	Genital Warts	PID	Syphilis
HIV	Bacterial Vaginosis	Trichomonas	Hepatitis B or C	Yeast	

(turn over)

How many different sex partners have you had in the last 12 months? _____

Were your partners *(circle correct answers)*: men women both IV drug users bisexual
a partner with multiple sex partners or at risk for HIV or STD infection

How long have you been with your current sex partner(s)? _____

What type of sex have you had in the past 2 months? *(circle the types)*

Vaginal Oral Anal Other No Sex

Do you have symptoms of a genital infection? **NO** ❒ **YES** ❒ *(circle the ones you have)*

Discharge	Odor	Itch	Rash
Bumps	Sores	Pain with sex	Bleeding after sex
Burning	Stool or anal problems	Pain with urination	Urgent or frequent urination

Have you used a birth control method before? **NO** ❒ **YES** ❒ *(Circle the types you have used and write in years of use:)*

Pills	Condoms	Diaphragm	Norplant
IUD	Shot/Depo	Vasectomy/Tubal	Abstinence
Withdrawal	Suppository/Film/Foam	Natural Family Planning/Rhythm	Other

What do you use now? _____

List any problems with your current methods:

Have you used birth control pills or injections for more than 5 years? **NO** ❒ **YES** ❒
(this can prevent cancer of the ovaries and uterus)

Are you up to date with your immunizations like Rubella or Hepatitis? **NO** ❒ **YES** ❒ **UNKNOWN** ❒

How old were you when you had your first period? Age: _____

For your most recent period, what was the first day bleeding started? Date: _____

How many days do your periods last? # of days: _____

How many days from the start of one period until the start of the next period? # of days: _____

When was the last time you had sex with a male without birth control? Date: _____

Do you think you could be pregnant today? **NO** ❒ **YES** ❒

Do you ever douche or use genital deodorant sprays, powders or wipes? **NO** ❒ **YES** ❒

Will this be your first pelvic exam today? **NO** ❒ **YES** ❒ Date of your last Pap test: _____

Have your Pap tests been normal? **NO** ❒ **YES** ❒ DES exposure **NO** ❒ **YES** ❒

If you have had an abnormal Pap test, when, where, and what was done? _____

Have you ever been pregnant? **NO** ❒ **YES** ❒ *(If no, you are done)*

# of pregnancies _____ # of deliveries _____
# of living children _____ # of abortions _____ # of miscarriages _____

If you have been pregnant before, when did your last pregnancy end? Date: _____

When you were pregnant, did you get diabetes? **NO** ❒ **YES** ❒

Have any of your babies been 10 pounds or more? **NO** ❒ **YES** ❒ no babies ❒

History reviewed by: _____

Date: _____

Public Health
Seattle & King County

Chart Label